

««« ««« ««« ««« **ALPHA-OMEGA** »»» »»» »»» »»»

ORTHOTICS & PROSTHETICS, INC.

Toll Free: 888.758.0717

DATE: _____

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ DATE OF BIRTH: _____

SEX: Male Female

SOCIAL SECURITY # _____

Height: _____ Weight: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED

PATIENT EMPLOYER: _____ PHONE #: _____

NEXT OF KIN: _____ RELATIONSHIP _____ PHONE #: _____

PRESCRIBING PHYSICIAN: _____ PHONE #: _____

DIAGNOSIS: _____ DATE OF INJURY/SURGERY: _____

INSURANCE INFORMATION

SELF PAY MEDICARE MEDICAID PRIVATE WORKMEN'S COMP VOC REHAB LAWSUIT

INSURED'S EMPLOYER: _____ PHONE #: _____

PRIMARY INSURANCE: _____ PHONE#: _____

ID # _____ GROUP # _____ POLICY #: _____

SECONDARY INSURANCE: _____ PHONE#: _____

ID # _____ GROUP # _____ POLICY #: _____

HOW DID YOU HEAR ABOUT US?

Doctor's Referral Newspaper Radio TV Friend Other: _____

PATIENT MEDICAL RECORDS RELEASE AUTHORIZATION

I _____ understand the below signature authorizes any holder of medical records about me to be released to *Alpha-Omega Orthotics & Prosthetics, Inc.* or its agents which might be needed to determine medical necessity, or receive benefits payable for any related services.

I also understand that my signature authorizes insurance benefits be made payable on my behalf to *Alpha-Omega Orthotics & Prosthetics, Inc.* for any services or treatment provided to me by said supplier. I also permit a copy of this authorization to be used in place of the original, and as a signature on file.

Patient or Legal Guardian/Representative Signature Date

Printed name of above signature

Springfield Office
2021 S. Waverly, Suite 300
Springfield, MO 65804
417.886.8881

Bolivar Office
495 S. Main Suite C.
Bolivar, MO 65613
417.326.2667

West Plains Office
308 Kentucky Avenue, Suite 4
West Plains, MO 65775
417.257.7411

FINANCIAL POLICY

INSURANCE INFORMATION IS REQUIRED AT TIME OF SERVICE. IF YOUR INSURANCE AUTHORIZES PAYMENT AND/OR PARTIAL PAYMENT, YOU WILL ONLY BE RESPONSIBLE FOR THE PORTION YOUR INSURANCE COMPANY WILL NOT PAY (USUALLY 20%).

IN THE EVENT THE INSURANCE PAYMENT FROM THE INSURANCE COMPANY IS MAILED TO YOU, AND A BALANCE IS OWED, THE CHECK MUST BE ENDORSED AND MAILED TO US. IF ANY OVERPAYMENT IS MADE TO US, WE WILL REIMBURSE YOU THE OVERPAYMENT AMOUNT.

MEDICARE PATIENTS: WE ACCEPT ASSIGNMENT ON MOST MEDICARE CLAIMS AND THEY WILL BE FILED DIRECTLY BY OUR OFFICE. IN MOST INSTANCES, MEDICARE REIMBUSES AT 80% OF WHAT THEY CONSIDER A REASONABLE CHARGE LESS ANY DEDUCTIBLE AND CO-INSURANCE AMOUNT. YOU WILL BE RESPONSIBLE FOR THE DEDUCTIBLE AND CO-INSURANCE AMOUNTS AT THE TIME OF DELIVERY. IN CERTAIN CASES, WE WILL BILL MEDICARE AND YOUR SUPPLEMENTAL INSURANCE DIRECTLY, BUT THIS MUST BE ARRANGED WITH THE OFFICE UPON COMPLETION OF INITIAL VISIT.

MEDICAID PATIENTS: A CURRENT COPY OF YOUR MEDICAID CARD MUST BE ON FILE IN ORDER TO VERIFY COVERAGE. AFTER EVALUATION, YOU WILL BE INFORMED IF THE PARTICULAR SERVICE RECOMMENDED IS COVERED BY MEDICAID.

HMO/PPO MEMBERS: PRIOR AUTHORIZATION MUST BE RECEIVED BEFORE WORK IS STARTED. YOUR PRESCRIPTION MUST BE FROM AN AUTHORIZED HMO/PPO PHYSICIAN FOR IT TO BE APPROVED.

WORKMAN'S COMPENSATION PATIENTS: WE MUST BE ABLE TO VERIFY THE CLAIM AND RECEIVE PRIOR AUTHORIZATION BEFORE WORK IS STARTED.

PAYMENT RESPONSIBILITY: IF YOUR PRIMARY INSURANCE WILL NOT AUTHORIZE PAYMENT, YOU WILL BE INFORMED OF THIS AND BE RESPONSIBLE FOR THE ENTIRE AMOUNT AT THE TIME OF DELIVERY UNLESS PRIOR ARRANGEMENTS ARE MADE.

ALL COPAYS WILL NEED TO BE PAID AT THE TIME OF DELIVERY, UNLESS YOU ARE ALSO COVERED BY MEDICAID, OR WORKMAN'S COMPENSATION. OUR OFFICE WILL GLADLY FILE PRIMARY BILLING FOR YOUR REIMBURSEMENT.

I UNDERSTAND THE ABOVE STATEMENTS AND AGREE THAT IN THE EVENT OF NON-PAYMENT OF AMOUNTS OWED FOR WORK AND MATERIALS PROVIDED TO ME BY ALPHA-OMEGA ORTHOTICS AND PROSTHETICS, INC., I AM RESPONSIBLE FOR THE ENTIRE AMOUNT OF THE BILL, REGARDLESS OF WHETHER OR NOT MY INSURANCE COMPANY, OR ANY OTHER THIRD-PARTY INSURER SUCH AS MEDICARE, PAYS ANY PORTION OF THE BILL. I AGREE TO PAY ANY ATTORNEY FEES AND COURT COSTS THAT ALPHA-OMEGA ORTHOTICS AND PROSTHETICS, INC. MAY INCUR IN COLLECTING ANY SUMS OWED. _____

Patient's or Guardian's Signature

Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- Home Telephone [redacted]
- O.K. to leave message with detailed information
- Leave message with call-back number only

- Written Communication
- O.K. to mail to my home address
- O.K. to mail to my work/office address
- O.K. to fax to this number

Message may be left with: (Name & Relationship)

- Work Telephone [redacted]
- Leave message with call-back number only
- Other _____

Patient Signature

Date

Print Name

Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: USES AND DISCLOSURES FOR TPO MAY BE PERMITTED WITHOUT PRIOR CONSENT IN AN EMERGENCY.

Date	Disclosed To Whom Address or Fax #	(1)	Description of Disclosure/Purpose of Disclosure	By Whom Disclosed	(2)	(3)

- (1) Check here if individual is informed
- (2) T-Treatment; P-Payment; O-Health Care Operations
- (3) F-Fax; P-Phone; E-E-Mail; M-Mail; and O-Office

ORTHOTICS & PROSTHETICS, INC.

Toll Free: 888.758.0717

***Consent to the Use and Disclosure of Health Information
for Treatment, Payment and Healthcare Operations***

I understand that as part of my healthcare, Alpha-Omega Orthotics and Prosthetics originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatments
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and procedure information to my bill
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the option of receiving a copy of the *Privacy Notification* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Alpha-Omega Orthotics and Prosthetics reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided, if I request. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and Alpha-Omega Orthotics and Prosthetics is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Alpha-Omega Orthotics and Prosthetics has already taken action in reliance thereon.

No Restrictions

I request the following restriction to the use or disclosure of my health information

 Signature of Patient or Legal Representative

 Witness

 Date

 Notice Effective Date

Unable to obtain consent because:

- True Emergency; Patient non responsive; Patient confused/disorientated;
 Patient has been sedated; _____

This area for use by Practice personnel only
 Restriction Accepted

Denied

 Signature Title Date

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of health care operations by Alpha-Omega Orthotics & Prosthetics. The Notice of Privacy Practices also describes my rights and duties of Alpha-Omega Orthotics & Prosthetics, with respect to my protected health information. The Notice of Privacy Practices is posted in the waiting area.

Alpha-Omega Orthotics & Prosthetics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

I also acknowledge that I have received a copy of the Medicare Supplier Standards as required by Medicare standards. The standards, in brief, describe my right and the obligations of Alpha-Omega Orthotics & Prosthetics as related to their contract with Medicare as a provider.

Signature of Patient or Personal Representative

Date

Important Changes in Reimbursement Policies



- **Governmental scrutiny of claims has increased dramatically.**
- **For any new orthosis or prosthesis, as well as major repairs to them, you must have a prescription for said device, and your physician must have physically seen you within the last 6 months, and examined your device(s).**
 - They must also document your specific function abilities or deficits, as well as your current need for a device, as required by Medicare/Medicaid coverage criteria.
 - If this detailed physician report of your visit is not noted in your medical chart, the insurance claim will most likely be denied, or funds that have previously been paid on your claim may be recouped.
 - A prescription is only viewed as the initial physician referral, and not as proof that an orthosis or prosthesis is actually needed. A prescription alone will not guarantee insurance payment.
- **After your evaluation by this office, your physician and/or therapist will be contacted and specific information regarding your medical condition as it relates to the device prescribed will be obtained.**
 - No work can commence until we have this detailed documentation on file as currently recommended by the Center for Medicare/Medicaid, and by extension other insurance providers, for insurance reimbursement.
- **An additional evaluation from a physical therapist may be recommended by your physician to help fulfill some of these documentation requirements.**
 - This information will include functional levels, as well as activities of daily living.
- **More than likely, there will be setbacks in the process due to this increased scrutiny. Unfortunately, this is a necessary step in order to assure your claim has the best chance to be paid properly in the new insurance environment.**
- **We are working diligently to make this transition as smooth as possible, but realize that some delays are inevitable.**
 - Company policy has been altered to accommodate the new changes.
 - Should you have any other questions regarding these insurance regulations, please feel free to discuss them with our billing office, your insurance, or your practitioner.



MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

- A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
- A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
- A supplier must have an authorized individual (whose signature is binding) sign the enrollment application for billing privileges.
- A supplier must fill orders from its own inventory, or contract with other companies for the purchase of items necessary to fill orders. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.
- A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
- A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
- A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
- A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
- A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
- A supplier must have comprehensive liability insurance in the amount of at least \$300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
- A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57 (c) (11).
- A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
- A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
- A supplier must maintain and replace at no charge or repair cost either directly, or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
- A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
- A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
- A supplier must disclose any person having ownership, financial, or control interest in the supplier.
- A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
- A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
- Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
- A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
- All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals).
- All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
- All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
- All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
- A supplier must meet the surety bond requirements specified in 42 CFR § 424.57 (d).
- A supplier must obtain oxygen from a state-licensed oxygen supplier.
- A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
- A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
- A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

MEDICARE DMEPOS SUPPLIER STANDARDS

DMEPOS suppliers have the option to disclose the following statement to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary.

The products and/or services provided to you by (supplier legal business name or DBA) are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at <http://ecfr.gpoaccess.gov>. Upon request we will furnish you a written copy of the standards.